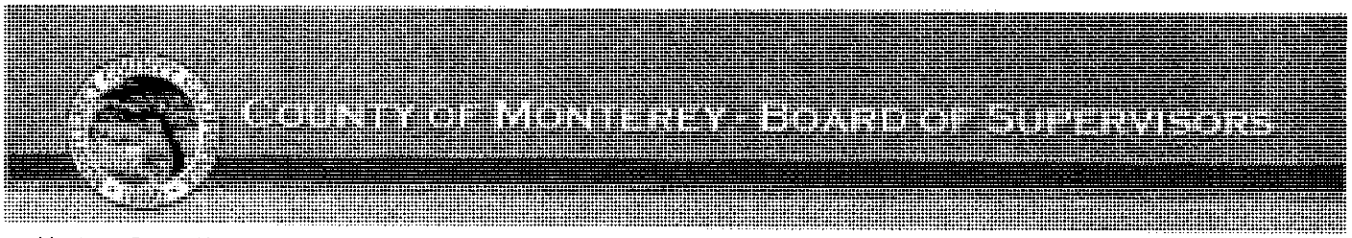

File #:	A 12-100 Version: 1	Name:	3M Company Amendment #2
Type:	BoS Agreement	Status:	Consent Agenda
File created:	5/18/2012	In control:	Board of Supervisors
On agenda:	6/26/2012	Final action:	
Title:	Authorize the Purchasing Manager for Natividad Medical Center (NMC) to execute Amendment No. 2 to the Agreement (SC2222) with 3M Company for Medical Records Coding Software Maintenance, and; ICD-10 Software Implementation, License & Maintenance, and; Assessments & Training services at NMC, extending the Agreement to August 8, 2015 and adding $554,250.31, over three years, for a revised total Agreement amount not to exceed $726,367.91 in the aggregate.		
Attachments:	6-12-12 3M Company Amendment #2, ATTACHMENT A, 3M Amendment #2		

Title
Authorize the Purchasing Manager for Natividad Medical Center (NMC) to execute Amendment No. 2 to the Agreement (SC2222) with 3M Company for Medical Records Coding Software Maintenance, and; ICD-10 Software Implementation, License & Maintenance, and; Assessments & Training services at NMC, extending the Agreement to August 8, 2015 and adding $554,250.31, over three years, for a revised total Agreement amount not to exceed $726,367.91 in the aggregate.

Body
RECOMMENDATION:
It is recommended the Board of Supervisors authorize the Purchasing Manager for Natividad Medical Center (NMC) to execute Amendment No. 2 to the Agreement (SC2222) with 3M Company for Medical Records Coding Software Maintenance, and; ICD-10 Software Implementation, License & Maintenance, and; Assessments & Training services at NMC, extending the Agreement to August 8, 2015 and adding $554,250.31, over three years, for a revised total Agreement amount not to exceed $726,367.91 in the aggregate.

SUMMARY/DISCUSSION:
Medical Coding Services; Items 3-9 on the 3M Company, Amendment #2
Accurate coding is at the core of the decision-making process which affects every level of service at NMC. Changes made to improve quality as well as obtaining new services for the public we serve are based on the data acquired from the medical record. It is becoming increasingly more difficult for coders to keep up with the frequent changes, various rules and regulations that govern the health care industry. Understanding classification guidelines, clinical information and the diverse payment methodologies of our payer sources is very challenging. Maintaining the 3M software upgrade allows the coder to navigate through the coding process with efficiency as well obtain the appropriate reimbursement for the organization.

Medical Necessity Dictionaries for Medi-Cal and Medicare; Items 10-11 on the 3M Company, Amendment #2
Medical necessity is a United States <http://en.wikipedia.org/wiki/United_States> legal doctrine <http://en.wikipedia.org/wiki/Legal_doctrine>, related to activities which may be justified as reasonable, necessary, and/or appropriate, based on evidence-based <http://en.wikipedia.org/wiki/Evidence-based_medicine> clinical standards of care <http://en.wikipedia.org/wiki/Standard_of_care>. Medicare <http://en.wikipedia.org/wiki/Medicare_(United_States)> and Medi-Cal pay for medical items and services that are "reasonable and necessary" for a variety of purposes. By statute, Medicare and Medi-Cal may only pay for items and services that are "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member", unless there

is another statutory authorization for payment
3M offers medical necessity edits and content to help clinicians and coders validate that medical procedures are necessary and appropriate before services are rendered. By operating throughout the revenue cycle, the 3M□ Medical Necessity Dictionaries will help minimize compliance risk and reduce denials, rework and payment delays.
In a pre-service environment such as a physician office, patient access, point of service, etc., the 3M Medical Necessity Dictionaries (for Medicare Part A and Part B) can be embedded within NMC's existing Meditech Health Care Information System (HCIS) to provide automatic medical necessity validation during scheduling and registration.

ICD-10, Assessment, Training and Software License & Maintenance; Items 12-20 on the 3M Company Amendment #2
The Department of Health and Human Services has mandated that ICD-9-CM code sets that medical coders & billers in the US currently use to report health care diagnoses and procedures, be replaced with ICD-10 code sets, effective Oct. 1, 2014. Additional information regarding this mandate is included in Attachment A. The services and software described in items 12-20 will assist NMC in determining what will be needed, and include the software, to meet this mandate.

OTHER AGENCY INVOLVEMENT:
County Counsel has reviewed and approved this Amendment as to legal form and risk provisions. Auditor-Controller has reviewed and approved this Amendment as to fiscal provisions. The Amendment has also been reviewed and approved by Natividad Medical Center's Board of Trustees.

FINANCING:
The cost for this Amendment over three years is $554,250.31. $245,842.55 is included in the Fiscal Year 2012/2013 Recommended Budget. $157,709.64 will be included in the Fiscal Year 2013/14 Recommended Budget and $150,698.11 will be included in the Fiscal Year 2014/15 Recommended Budget. There is no impact to the General Fund.

Prepared by: Jim Fenstermaker, IT Director, 783-2559
Approved by: Harry Weis, Chief Executive Officer, 783-2553

Attachments: Attachment A, Agreement, Amendments 1 and 2.

Monterey County

168 West Alisal Street,
1st Floor
Salinas, CA 93901
831.755.5066

Board Order

Agreement No. A 12260

Upon motion of Supervisor Parker, seconded by Supervisor Armenta, and carried by those members present, the Board of Supervisors hereby:

Authorized the Purchasing Manager for Natividad Medical Center (NMC) to execute Amendment No. 2 to the Agreement (SC2222) with 3M Company for Medical Records Coding Software Maintenance, and; ICD-10 Software Implementation, License & Maintenance, and; Assessments & Training services at NMC, extending the Agreement to August 8, 2015 and adding $554,250.31, over three years, for a revised total Agreement amount not to exceed $726,367.91 in the aggregate.

PASSED AND ADOPTED on this 26th day of June 2012, by the following vote, to-wit:

AYES: Supervisors Armenta, Calcagno, Salinas, Parker, and Potter
NOES: None
ABSENT: None

I, Gail T. Borkowski, Clerk of the Board of Supervisors of the County of Monterey, State of California, hereby certify that the foregoing is a true copy of an original order of said Board of Supervisors duly made and entered in the minutes thereof of Minute Book 76 for the meeting on June 26, 2012.

Dated: July 20, 2012
File Number: A 12-100

Gail T. Borkowski, Clerk of the Board of Supervisors
County of Monterey, State of California

By _____
Deputy

AMENDMENT 2
TO THE
SOFTWARE LICENSE AGREEMENT

THIS AMENDMENT to the Software License Agreement a/k/a the Software License and Services Agreement, dated August 9, 2010 (as amended, the "Agreement") between 3M Company, together with its subsidiaries and affiliates, (collectively referred to herein as "3M") having an office at 575 West Murray Boulevard, Murray, Utah 84123-4611 and Natividad Medical Center (hereinafter referred to as "Customer") with offices at 1441 Constitution Blvd, Salinas, CA 93906-3100 shall be effective as of July 1, 2012 **("Effective Date").**

Customer and 3M agree that the above referenced Agreement is amended as follows:

1. Except as provided in this Amendment, all terms and conditions of the above referenced Agreement will remain in full force and effect.

2. AMEND Exhibit B, the Software and Services Schedule, as follows:

S/O ITEM	CPU ACTION	SKU	PRODUCT DESCRIPTION	SITE TYPE LIST FEE	ANNUAL FEE 2012-2013	ANNUAL FEE 2013-2014	ANNUAL FEE 2014-2015
83550	*Networking*	--	*NATIVIDAD MEDICAL CENTER--SALINAS, CA , HI2930399*	*Install/Access Site*			
3.	Renew	CRSNOCAS	Coding & Reimbursement System without Clinical Analyzer Software	$53,960.00	$41,631.21	$43,712.77	$45,024.15
4.	Renew	APC	APCfinder Software	$9,149.00	$6,959.83	$7,307.82	$7,527.06
5.	Renew	S-APR-DRG	S-All Patient Refined DRG Software	$19,903.00	$15,464.97	$16,238.22	$16,725.36
6.	Renew	APRDRGCAS	Advanced Analyzer	$21,798.00	$16,785.25	$17,624.51	$18,153.25
7.	Renew	CODREF	Coding Reference Software†	$5,090.00	$4,820.25	$5,061.26	$5,213.10
8.	Renew	CODREFPL	Coding Reference Plus Software†	$4,268.00	$3,922.80	$4,118.94	$4,242.51
9.	Renew	CONNSFT BAS	Connections Software Basic	$2,327.00	$2,326.31	$2,442.62	$2,515.90
			For the purpose of this Agreement, the Software Implementation Date for the products listed above is deemed to be September 17, 2011.				
10.	Add	MND MED CA	Medical Necessity Dictionaries Medi-Cal - 4000000000150	$19,628.00	[1,2] $9,814.00	$10,304.70	$10,613.84
11.	Add	MND CA A	Medical Necessity Dictionaries CA Part A - 4000000000008	$19,628.00	[2] $16,683.80	$17,517.99	$18,043.53
12.	Add	PCRS	Physician Coding And Reimbursement System	$11,187.00	[2] $9,173.34	$9,632.01	$9,920.97
13.	Add	PCRS I&T	Physician Coding And Reimbursement System I&T*	$500.00	$500.00	N/A	N/A
14.	Add	ICD-10 EDUCATION	ICD-10 Education Program	$14,251.00	[3] $11,400.80	$11,400.80	N/A
15.	Add	CTT ICD10 ENTERPRISE	ICD10 Code Translation Tool Enterprise	$14,700.00	$11,760.00	$12,348.00	$12,718.44
16.		CTT ICD10 I&T	ICD10 Code Translation Tool Installation	$500.00	$500.00		
17.	Add	ICD10PRS-IP	ICD-10 Assessment - Inpatient**	$27,200.00	$27,200.00	N/A	N/A
18.	Add	ICD10PRS-PROF	ICD-10 Assessment - Professional**	$27,200.00	$27,200.00	N/A	N/A
19.	Add	ICD10 FINIMPACT	ICD-10 Provider Financial Impact*	$7,500.00	$7,500.00	N/A	N/A
20.	Add	ICD10 FIAOUTPUT	ICD 10 Financial Impact Analysis Output File**	$5,000.00	$5,000.00	N/A	N/A
21.	Add	ICD10PRS-OP	ICD-10 Assessment - Outpatient	$27,200.00	$27,200.00	N/A	N/A
			SCHEDULE TOTAL:		*$245,842.56*	*$157,709.64*	*$150,698.11*

FEE SUMMARY:

ANNUAL SOFTWARE LICENSE & SUPPORT FEES:	$177,942.56
*TOTAL ONE TIME, IMPLEMENTATION & TRAINING FEES:	$1,000.00
**TOTAL CONSULTING SERVICES FEES:	$66,900.00

TOTAL THIS AMENDMENT:	$245,842.56

THE FEES LISTED ABOVE ARE GUARANTEED FOR A PERIOD OF NINETY (90) DAYS FROM THE ISSUE DATE LISTED BELOW OR DECEMBER 31, 2012, WHICHEVER OCCURS FIRST, UNLESS THIS AMENDMENT IS FULLY EXECUTED PRIOR TO.

In the event Customer delays implementation of any module of Software or scheduling of Services, at no fault of 3M, for more than one hundred fifty (150) days from the execution date of this Amendment, 3M may, at its option, increase the price of such Software or Service to the then-current list price or 3M may terminate any such module of the Software or Service from this Agreement.

Deletion = ♦ Underscored Text = Addition I&T = Implementation and Training PI = Phone Installed CI = Customer Installed † Includes third party content

[1] Subject to Section 8.1.e.

[2] The fees list about will be prorated based upon the implementation date of the software.

[3] The 3M ICD-10 Education Program shall be provided to Customer under the terms and conditions of the Agreement and the 3M ICD-10 Education Program Terms of Use, attached hereto as Exhibit E and made part of the Agreement by this reference.

22. ADD Section 2.10 to the terms and conditions.

2.10 Interface Development. **Customer's use** of the 3M Software and Documents licensed under this Agreement to create, install and support interfaces is limited to those interfaces created by Customer that are necessary to enable the communication of data, objects or methods (including, but not limited to, codes, edits, indicators, modifiers, flags or other output **– collectively referred to herein as "3M Software Output") between and among the 3M Software licensed hereunder and those applications or systems developed and deployed internally** by the Customer **("Customer Applications"). For purposes of clarity and the avoidance of any dispute, Customer Applications do not include any application and/or system that is sold, licensed or otherwise made available to Customer by a third party ("Third Party Vendor Application").** Customer shall not: (i) use the 3M Software or Documents to create any interface (or functionally-equivalent application) that enables the communication of 3M Software Output to any Third Party Vendor Application, or (ii) make the 3M Software or Documents available or accessible to any Third Party Vendor, or agent thereof, for purposes of enabling such Third Party Vendor to create such an interface. All interfaces that are necessary to enable the communication of 3M Software Output between and among the 3M Software and any Third Party Vendor Application shall be developed and implemented by 3M and/or the Third Party Vendor, provided that such Third Party Vendor has a current Interface License Agreement in effect with 3M.

23. ADD the following to the end of the last sentence of Section 3.2 (Customer Obligations) to the terms and conditions.

"and (ix) provide 3M with a list of all Customer Applications as defined in Section 2.10, and advise 3M of any changes to such list."

24. ADD Section 8.1.e to the terms and conditions.

8.1.e. Additional Software. Customer has licensed an additional copy of Software at a discounted rate based upon the original **Software's current license fee.** In the event that Customer cancels the original copy of the Software from the Agreement, the additional copy of the Software will be priced at the then-current list price for the Software, less any applicable discount.

25. DELETE Section 9.1.1 of the terms and conditions in its entirety and REPLACE it with the following:

9.1.1 License Term Extension. Customer agrees to license the Software listed in this Agreement from 3M for an extended three (3) year term beginning August 9, 2012 and ending August 8, 2015 (**"Extended Term"**). After the Extended Term, this Agreement, and the License granted under Section 2.5, shall automatically terminate unless Customer, upon sixty (60) days prior written notice, requests renewal. Such renewal, if any, would be priced at 3M's then-current list price, less any applicable discount. 3M, at its option, may elect not to renew the Agreement.

26. ADD Exhibit F to this Agreement.

[Signature to follow on next page]

[Intentionally Left Blank for Signatures]

A. Bree
Deputy County Counsel
as to form only
. see email

Reviewed as to fiscal provisions
Auditor-Controller
County of Monterey 5-8-12

Customer has read this Amendment, and when applicable, each Exhibit, and Attachment hereto. To indicate Customer's acceptance and agreement to be bound by the terms and conditions of this Amendment, 3M and Customer have executed this Amendment on the date(s) indicated below, to be effective as of the date first indicated above.

NATIVIDAD MEDICAL CENTER	3M COMPANY
BY	
NAME Henry Wein	NAME James R. McDonough
TITLE CEO	TITLE Pricing and Contracting Director
DATE 4/26/12	DATE April 5, 2012

PLEASE FAX YOUR PURCHASE ORDER IN THE AMOUNT OF $245,842.56 AND THE SIGNED AMENDMENT TO: (651) 732-8469

ISSUE DATE:	GPO:	BATCH NUMBER:	CLIENT SITE ID:	AGREEMENT NUMBER:
1/28/2012 SHH	**********	GR98G3	2930399	001553-10 SLA
REVISION DATE:	SLA TYPE :			
4/5/2012 TS	SLSA 04/09			

EXHIBIT E

3M ICD-10 EDUCATION PROGRAM TERMS OF USE ADDENDUM

The following terms and conditions apply to Customer's use of the 3M ICD-10 Education Program in addition to the terms and conditions set forth in the Agreement. In the event of a conflict between the terms and conditions in the Agreement and those set forth on this Addendum, with respect to Customer's use of the 3M ICD-10 Education Program, the terms and conditions of this Addendum shall control. Terms not otherwise defined hereinafter shall have the same meanings as defined in the Agreement.

A. Definitions. As related to the 3M ICD-10 Education Program:

A.1. **"Lesson"** means a set of instructional materials developed by, or on behalf of, 3M, including, but not limited to, instructional material, self-practice lessons, test questions, and advanced reporting services, including any changes thereto, or new versions or releases thereof.

A.2. **"Program"** means a set of one or more web-based self-service Lessons accessed by Customer and Customer's Trainee(s) over the internet.

A.3. **"Program Term"** means the term of the subscription beginning on the Effective Date of the Amendment adding the 3M ICD-10 Education Program to the Agreement and unless otherwise terminated, or extended, in accordance with the Agreement, will automatically terminate on July 31, 2014. 3M reserves the right not to extend the Program Term.

A.4. **"Trainee(s)"** means a Customer's employee(s), including employee(s) of a physician office (owned or managed by Customer) and/or independent contractor(s) under direct contract with Customer who Customer provides a corporate email account. TRAINEE(S) DO NOT INCLUDE CONSULTANTS AND/OR CONTRACT WORKERS EMPLOYED BY A THIRD PARTY CONTRACTED TO PERFORM, ON A TEMPORARY BASIS, THE SAME OR SIMILAR FUNCTIONS OF CUSTOMER'S EMPLOYEES AND/OR EMPLOYEE(S) OF A PHYSICIAN OFFICE WHO ARE NOT DIRECTLY OWNED AND/OR MANAGED BY CUSTOMER AND/OR INDEPENDENT CONTRACTOR(S) WHO ARE NOT ISSUED A CORPORATE EMAIL ACCOUNT BY CUSTOMER.

B. Program

B.1. Lesson Access. During the Program Term, subject to the Customer's obligation to pay the annual Program fees and any rights and limitations described in the Agreement or this Addendum, 3M grants Customer and its Trainee(s), a nontransferable, nonexclusive, non-sublicensable, revocable license to access the Program via the internet and to use the Program and Documents for its internal business purpose only. Customer and its Trainee(s) must comply with all website legal notices and policies applicable to the access and use of the Program. Subject to Section 4 (Confidential Information) of the Agreement, Customer will supply, in a form suitable to 3M, a list of its Trainee(s) requiring access to the Program which shall be used solely for the purpose of providing the Program to Customer and Customer's Trainee(s). Subject to Section 2 (Password Security) of the Agreement, 3M shall supply Customer with the password(s) necessary for Customer and its Trainee(s) to access the Program and Customer shall be solely responsible for maintaining the password(s) in confidence. During the Program Term Customer may, add a Trainee(s) with reasonable advanced written notice to 3M (without additional cost or expense) and/or terminate a Trainee(s) (with no refund or credit due Customer). Customer, at its sole cost and expense, is responsible for providing any third party printed materials (e.g. ICD-10-CM Code Set, ICD-10-PCS Code Set), servicing, maintaining, and updating all equipment, computers, software, and communication services (including access charges incurred in connecting to the Internet) not owned or operated by or on behalf of 3M, that permit Customer and its Trainee(s) to access and use the Lessons in accordance with the Program Documents, Instructions, procedures, and system requirements that may be issued by 3M, and amended by 3M, from time to time, which are available from https://support.3Mhis.com. 3M does not make any commitments with respect to use or performance of the Program. 3M reserves the right to limit Customer's and Customer's Trainee(s) access to the Program, without advance notice, for maintenance purposes.

B.2. Restrictions. The Program contains materials that are proprietary to 3M and its suppliers. Subject to Section 2.1 (Ownership) of the Agreement, Customer and Customer's Trainee(s) are specifically prohibited from downloading or copying (unless specifically permitted) the Program and/or the Lessons (in whole or in part). Notwithstanding the forgoing, Customer and Customer's Trainee(s) may download items that 3M makes available from the Program ("Materials"), provided that (1) the copyright notice appears on all copies and, (2) use of such Materials from the Program is for informational and non-commercial or personal use only and will not be copied or posted on any network computer or broadcast in any media, and (3) no modifications of any Materials are made. Customer will not use any device, software, routine, or take any action that interferes with the proper working of the Program.

B.3. Conditions of Use; Termination. As a condition of Customer's and its Trainee(s) use of the Program; 3M, reserves the right to, without notice or obligation: (i) automatically update the Program (updates are designed to improve, enhance and further develop the Program and may take the form of bug fixes, enhanced functions, new Lessons and completely new versions), or (ii) modify a Lesson (or all Lessons) or, (iii) discontinue a Lesson (or all Lessons) at any time. In the event 3M discontinues all the Lessons, 3M's sole obligation and Customer's sole and exclusive remedy shall be for 3M to refund (or credit) to Customer a prorated portion of the prepaid

license fees. In addition, notwithstanding the Section 9.2 (Termination) of the Agreement, 3M may terminate the Program license immediately and without obligation of refund (or credit) if Customer or any of its Trainee(s) violates a provision of the Agreement, this Addendum, the web site terms and conditions, or any instructions and policies provided by the Program and the violation is not remedied to 3M's satisfaction within thirty (30) days after Customer receives written notice of the breach from 3M.

C. Disclaimer of Warranties. 3M AND ITS SUPPLIERS DO NOT WARRANT THAT **CUSTOMER AND CUSTOMER'S TRAINEE(S) ACCESS TO OR USE OF THE PROGRAM WILL BE UNINTERRUPTED OR ERROR FREE. IN ADDITION, CUSTOMER AND CUSTOMER'S TRAINEE(S) ACCESS TO THE PROGRAM IS PROVIDED "AS IS" AND "AS AVAILABLE" WITHOUT WARRANTY OF ANY KIND, EITHER EXP**RESS OR IMPLIED. TO THE FULLEST EXTENT PERMISSIBLE BY APPLICABLE LAW 3M AND ITS SUPPLIERS DISCLAIM ALL WARRANTIES, EXPRESS OR IMPLIED, INCLUDING BUT NOT LIMITED TO THE IMPLIED WARRANTY OF MERCHANTABILITY, THE IMPLIED WARRANTY OF FITNESS FOR A PARTICULAR PURPOSE, AND ANY IMPLIED WARRANTY ARISING OUT OF A LEASON, OF DEALING, OR OF PERFORMANCE, CUSTOM OR USAGE OF TRADE.

D. Limitation of Liability. Subject to Section 7 (Excluded Damages) of the Agreement, the exclusive and maximum liability of 3M and its suppliers to Customer or Customer's Trainee(s) arising from the access to or use of (or inability to access or use) the Program due to any act or omission of 3M or its suppliers shall be for 3M to refund (or credit) to Customer the fees actually paid by Customer with respect to the Program.

E. Disclaimers. The material contained within the Program is for training purposes only and is not intended to be a substitute for the use of, and reference to, authoritative compliance references. Rules and regulations change, and are always subject to varying interpretation. Accordingly, 3M gives no assurance that use of the Program will prevent disagreements with Medicare or other third party payers with respect to documentation requirements, coding practices or payment for services in specific situations. Certification of Program completion is not a certification or guarantee of Trainee performance. For Customer's sole convenience, 3M may offer discussion forums and blog opportunities ("Forums") where Customer's Trainee(s) and other users can submit content for public viewing ("Forum Content") to facilitate Customer's socializing and networking with others interested in distance or online learning. Customer agrees that all Forum Content is the sole responsibility of the individual or entity from whom such Forum Content originated. This means that Customer (and not 3M) is solely responsible for all Forum Content that Customer or Customer's Trainee(s) submit via the Forum or elsewhere on the site. 3M does not control or guarantee the accuracy, completeness, usefulness, integrity, or quality of Forum Content. Additionally, 3M may provide links to third party websites. The existence of these links is not to be construed as an endorsement by 3M of the content of any of these external sites, nor does 3M take any responsibility for the content, the accuracy of the information and/or the quality of products or services provided by or advertised on these third party websites.

EXHIBIT F
SCOPE OF WORK

ICD-10 Documentation Assessment

Background and Objective

On January 15, 2009, the U.S. Department of Health and Human Services (HHS) published a final rule establishing ICD-10 as the new national coding standard. The implementation date, initially proposed for October 2011, has been set for October 1, 2013. Experts indicate that the adoption of the new ICD-10 code sets will:

- Allow more accurate definition of services and provides specific diagnosis and treatment information for a wider variety of illnesses and diseases.
- Provide more accurate data for tracking, reporting, and reimbursement, trending and purchasing decisions.
- Reduce claim rejection, improve disease management and allow for more accurate and comprehensive revenue recognition.

As a result of this final rule, after October 1, 2013, all patient records must begin using ICD-10-CM diagnosis codes for inpatient and outpatient and ICD-10-PCS procedure codes for inpatient, in order to receive reimbursement from Medicare and many other payors. ICD-10 greatly expands the number of valid diagnosis and procedures codes in order to address with more specificity a wider variety of illnesses and diseases. Appropriate documentation and accurate coding are even more important under ICD-10 given the increase in specificity supported under ICD-10 in order for the codes to be an accurate reflection of resources used, services rendered, and appropriate payment. Maintaining your current accuracy may require changes to your current documentation and coding processes and will minimally require some level of education of staff to understand the complexities of ICD-10.

Hospitals performing poorly within the current ICD-9/MS-DRGs system and with medical necessity issues in the outpatient arena, due to lack of documentation will also continue to perform poorly under ICD-10 as more specificity in documentation is required to assign the highest level of ICD-10 code. The ICD-10 version of MS-DRGs posted on the CMS website replicates the ICD-9 version of the MS-DRGs (subject to change between now and 2013). The posted version of ICD-10 version MS-DRGs is unlikely to cause a significant redistribution of payments across hospitals. CMS has not yet clarified how medical necessity for outpatient procedures will be impacted with the implementation of ICD-10.

The objective of the Services is to help you evaluate the areas within your patient population where additional documentation specificity will be required under ICD-10. Understanding the clinical areas that are most impacted by the switch to ICD-10 will assist you in making further decisions relating to personnel, educational opportunities and process improvement.

Scope and Approach

The scope of our Services will be to process a sample of your medical records and systematically identify where ICD-9-CM codes can be translated to multiple ICD-10 codes. Based on information from CMS, over 80% of ICD-9-CM diagnosis codes and 10% of ICD-9-CM procedure codes translate to a single ICD-10 code. Since claims involve multiple diagnosis codes repeated across many patient encounters, a hospital may have more than 20% of claims that do not translate to a single ICD-10 diagnosis code without further specificity. For procedure codes it is likely that the vast majority of codes will require further specificity in the medical record. However, the impact to your facility will depend upon your current utilization of individual ICD-9 codes within your patient population. The Services will determine the distribution of existing codes that do not translate to a single ICD-10 code within your current patient population by using your most recently coded ICD-9 records.

Based on our ICD-9 experience, a systematic approach of combining data analysis with actual chart review has been an effective model for isolating actionable change within existing processes. Our review will be conducted in a manner least disruptive to the Hospital's routine processes.

Data Request

Prior to the data analysis and record review, we request that a coordinator be designated to facilitate our review and assist with the data collection and sample selection. In addition, we require a conference call take place with one of our data analysts prior to the initiation of data collection for professional claims data.

We request to receive twelve (12) months of current inpatient Medicare data and/or one (1) month of current Medicare outpatient data and/or one (1) month of professional claims data.

Data Analysis

The data will be processed through a series of proprietary routines and utilities including the 3M™ ICD-10 Claims Analyzer Tool and the 3M™ ICD-10 Code Translation Tool. Once the inpatient data set is processed we will aggregate the record and code results to create the following statistics:

- Overall percent of records with an ICD-10 Specificity Count greater than 0 – indicates the number of records in your population directly impacted by ICD-10.

- Average ICD-10 Specificity Count – indicates how many codes are impacted per record.
- Rank order of MS-DRGs by highest average ICD-10 Specificity Count – indicates which MS-DRGs within your population are impacted the most by ICD-10.
- Rank order of MS-DRGs by volume with average ICD-10 Specificity Count – indicates how each top volume MS-DRG is impacted by ICD-10.
- Top five (5) MS-DRGs by Specialty ranked by highest average ICD-10 Specificity – indicates which MS-DRGs within Specialty within your population are impacted by ICD-10.

For the outpatient data set, we will aggregate the records and code results to create the following statistics:

- Overall percent of records with more than one translation directly impacted by ICD-10.
- Percent of claims with more than one translation by Service Line.
- Percent of records with a current medical necessity issue and with multiple code translations.
- Average ICD-10 Specificity Count – indicates how many codes are impacted per record.

For the professional claims data, once the data set is processed, we will aggregate the record and code results to create the following statistics:

- Overall percent of encounters with an ICD-10 Specificity Count greater than 0 – indicates the number of records in your population directly impacted by ICD-10.
- Overall percent of code with an ICD-10 with an ICD-10 Specificity Count greater than 0.
- Identify the average translation ratio by service line.
- Identify average translation ration by volume indication by service line.
- Average ICD-10 Specificity Count – indicates how many codes are impacted per record.

Upon completion of the data processing, we will identify by specialty, service line or professional practice the number and percent of records that will require additional specificity under ICD-10 (i.e., one or more codes map to more than one ICD-10 code), as well as the top ten (10) diagnosis codes by frequency that may require additional documentation. In addition, for the outpatient data set, we will identify by revenue code the top ten (10) diagnosis codes with medical necessity issues that may require additional documentation.

We will then review these statistics to identify a specific sample of records to review. We will provide the medical record numbers of the records within the sample in advance of our record review in order to have them pulled and available. We request to receive a copy of or have access to your internal coding guidelines and your QIO admission criteria to utilize during the review.

Onsite Record Review

We will review fifty (50) inpatient and/or one hundred (100) outpatient Medicare records, and/or one hundred (100) single professional encounters. The ICD-9-CM codes that have more than one potential ICD-10 code will be isolated and analyzed to determine if the documentation supports the ICD-10 specificity or granularity.

The sample of inpatient records will be a focused sample of records from the top five (5) Specialty areas ranked by highest average MS-DRGs within the Specialty of your population impacted by ICD-10.

The sample of outpatient records will be distributed as follows:

⇒ 15 Same Day Surgery

⇒ 10 GI Lab

⇒ 15 Emergency Department

⇒ 10 Observation

⇒ 5 Cardiac Cath

⇒ 20 Ancillary

⇒ 25 Clinic

The sample of professional services will be distributed as follows:

⇒ Ten (10) services from the top ten (10) high volume/high dollar professional services practice groups.

As applicable during the record review, our consultants will perform the following:

- Review the computerized coding summary or codes written on the front sheet.

- Perform a comprehensive review of chart documentation to assess the following for ICD-10 specificity:
  - ⇒ review of ICD-9-CM diagnosis codes;
  - ⇒ review of ICD-9-CM procedures codes (for inpatient records);
  - ⇒ verify principal diagnosis selection;
  - ⇒ review of existing documentation to determine highest ICD-10 code assignability;
  - ⇒ review of documentation improvement opportunities to code at a higher level of ICD-10 specificity;
  - ⇒ for professional encounters, identify for each ICD-9-CM code the Closest Match ICD-10 code, if one is available, as well as all potential ICD-10 codes that map to the ICD-9-CM code;
  - ⇒ application of all official coding rules and guidelines;
- Perform a code level analysis of those ICD-9-CM codes that have more than one potential ICD-10 code in order to assess the following:
  - ⇒ accuracy of Closest Match ICD-10 code; and,
  - ⇒ adequacy of clinical documentation to support the specificity of the potential ICD-10 codes.
- Document all ICD-9 and ICD-10 coding recommendations and findings on our coding review form and provide you with a copy for future reference.
- Review findings initially with HIM management and/or professional services management, and then a subsequent session with coding staff.

NOTE: Since ICD-10-PCS does not affect outpatient or professional coding, no procedure or visit codes will be reviewed.

Executive-Level Summation Meeting and Report

The components of this portion of the project are a standard part of our Services and should be of value to you, your staff and the Hospital. Specifically, we will:

- Periodically update you, and any other management-level personnel you designate, on the status of the project.
- Present an executive-level summation meeting with your management team to present and discuss our written report of findings and recommendations related to MS-DRG assignment, and documentation improvement opportunities under ICD-10 to support accurate coding.
- Provide a written summary report to include the following:
  - ⇒ comparative analysis of codes under ICD-9 and ICD-10;
  - ⇒ highlight service lines most impacted by ICD-10;
  - ⇒ identification of areas to focus staff education and,
  - ⇒ identification of where documentation should be reviewed to determine if I-10 specificity is present or if documentation gaps exists in ICD-10.
- Recommend to you and the management team any training and education of coders, and others, and any process improvements needed for ICD-10.

ICD-10 MS-DRG FINANCIAL IMPACT ANALYSIS

Background and Objective

The 3M ICD-10 MS-DRG Financial Impact Analysis is designed to assist hospitals in estimating the financial impact of transitioning from a ICD-9 based MS-DRG payment system to a ICD-10 based MS-DRG payment system. This analysis can be applied to Medicare patients using Medicare relative values and blended rates.

3M is uniquely qualified to provide this Service, having worked internationally with ICD-10 in several countries most notably Australia and Canada who both have been using ICD-DRG based systems for years and who made the transition to ICD-10 in 1998 and 2001 respectively. We are also the author of ICD-10 PCS, (Procedure Coding System) the inpatient procedure portion of ICD-10 and have worked on the PCS for over 15 years. 3M HIS was also chosen by CMS to create the General Equivalency Maps (GEMS) and we maintain the CMS MS-DRG groupers.

With this experience comes a unique, first-hand understanding of the logic of coding and grouping inpatient patient data into ICD-10-CM and ICD-10-PCS.

The 3M ICD-10 Financial Impact Analysis findings will provide important information to assist you in analyzing the potential impact of ICD-10 based MS-DRG classification within your organization.

Approach and scope

The approach and scope of our Services will be to utilize the Hospital's current Medicare discharge data and translate the ICD-9 codes to the closest matching ICD-10-CM and ICD-10-PCS codes. We will accomplish this translation using a combination of GEMS and coding guidelines to arrive at the closest ICD-10-CM/PCS code or codes for each ICD-9 code.

Translation Process

A significant number of ICD-9-CM diagnosis codes and a smaller percentage of ICD-9-CM Procedures codes have a single matching ICD-10-CM/PCS code. Translation of these one-to-one matches will be accomplished using a stralght substitution.

When more than one possible ICD-10 code is associated with an ICD-9 code, the translation process is more involved. The first step is to narrow the list of valid ICD-10 codes by using available demographic and ICD-9 information on the patient record. Using this information and our knowledge of ICD-10 will result in a refined list of valid ICD-10 translations. The second step in the translation process will be to select an ICD-10 code from the refined list of valid ICD-10 translations.

It is important to note that assignment of clinically accurate ICD-10 codes can only be accomplished through inspection of the original patient medical record. Since inspection of the original patient medical records is not possible, the translated ICD-10 codes may not reflect the actual clinical care provided to the patient. As a result of this selection process, the translated ICD-10 codes should only be used to evaluate potential shifts within and between MS-DRGs.

The final step in the translation process will be to apply proposed coding rules under ICD-10 that would result in different sequencing of principal and secondary diagnosis codes. For instance, within ICD-9 MS-DRGs, a diagnosis of anemia related to neoplastic disease (malignancy) is sequenced as the principal diagnosis when the admission is for the treatment of the anemia. Under ICD-10 Coding Guidelines, the malignancy is sequenced first followed by the anemia as a secondary diagnosis.

The result of the translation process is a complete set of ICD-10-CM and ICD-10-PCS codes that correspond as closely as possible to the original ICD-9-CM codes.

Comparing MS-DRGs under ICD-9 and ICD-10 and Computing Financial Impact

The original ICD-9-CM codes will be grouped into MS-DRGs using the current Medicare MS-DRG v28 grouper and the results stored. The translated ICD-10-CM/PCS codes will be grouped into MS-DRGs using the pilot ICD-10 MS-DRG v28 grouper released by CMS. This dual grouping process results in each record having an ICD-9 based MS-DRG and an ICD-10 based MS-DRG. Differences in these MS-DRGs will result in financial impact.

Using the current MS-DRG v28 relative values and your current blended rate, an estimated reimbursement and Case Mix Index can be computed for both the ICD based MS-DRGs and the ICD-10 based MS-DRG assigned to the patient record. Differences in MS-DRGs will result in a different relative value and therefore a different estimated reimbursement. Aggregating these changes across all patients results in an estimate of the financial and case mix impact of transitioning from ICD-9-CM to ICD-10-CM/PCS.

To pinpoint where financial and case mix index differences occur, the ICD-10 Financial Impact Analysis will provide:

- Comparison of estimated financial performance under MS-DRGs compared to ICD-10 MS-DRGs, to include:
  - ⇒ Aggregate comparison on estimated CMS payment using the ICD-9 and ICD-10 MS-DRG values;
  - ⇒ Summary analysis of financial performance between medical and surgical cases;
  - ⇒ Comparison of case mix indices under both methods;
  - ⇒ Summary and detailed analysis of financial impact by product line; and
  - ⇒ Detailed impact analysis of financial performance by admitting physician.

An offsite Executive Summary meeting will be held to review specific findings and recommendations, including next steps for ICD-10 success. Attendees should include the CEO, CFO, CIO, Chief Medical Officer, Compliance Officer, Physician Quality Director, Directors of Quality, Health Information Management and Case Management.

Due to the large number of pages in the detailed analysis report, we will provide you with an electronic PDF version of the final report. Specifically, the detailed analysis report will contain the following sections:

- ⇒ Estimated Documentation Improvement Opportunity under MS-DRGs;
- ⇒ Estimated financial impact dashboard by overall, medical and surgical;
- ⇒ Overall case mix index;
- ⇒ Medical/surgical case mix index;
- ⇒ Product line revenue;
- ⇒ Product line detail;

⇒ Product line by physician detail;

⇒ Physician detail by product line; and,

⇒ Product line list.

Please see Attachment A for data specifications.

Data Export File (Optional)

As an additional option, the Hospital may elect to receive an export file (Microsoft Office Excel, unless otherwise specified) of the detailed claims data containing the following elements per claim:

- Claims demographic information originally provided: Patient Control Number, beginning and ending dates, bill type, discharge status, total charges, and DRG.
- Physician information: admitting physician UPIN and name.
- Original ICD-9-CM diagnosis and procedure codes.
- Translated ICD-10-CM diagnosis codes and ICD-10-PCS procedure codes.
- ICD-9-based MS-DRG V28 assignment, weight, and description.
- ICD-9 Service Line information: service line description based on 3M's categorization of MS-DRGs.
- ICD-10-based MS-DRG V28 assignment, weight, and description.
- ICD-10 Service Line information: service line description based on 3M's categorization of MS-DRGs

It is important to note that assignment of clinically accurate ICD-10 codes can only be accomplished through inspection of the original patient medical record. Since inspection of the original patient medical records is not possible, the translated ICD-10 codes may not reflect the actual clinical care provided to the patient. As a result of this selection process, the translated ICD-10 codes should only be used to evaluate potential shifts within and between MS-DRGs.

DATA SPECIFICATIONS

Please see Attachment A for data specifications.

Hospital Responsibilities

In connection with 3M's provision of the Services, the Hospital will perform the tasks, furnish the personnel, provide the resources, or undertake the responsibilities specified below ("Hospital Responsibilities"):

- ICD-10 Documentation Assessments:
  - ⇒ Providing inpatient and/or outpatient discharge and/or professional claims data to allow for the sample selections.
  - ⇒ Pulling the selected charts and/or patient encounters.
  - ⇒ Providing access to internal coding guidelines and QIO admission criteria, or a copy thereof.
- ICD-10 MS-DRG Financial Impact Analysis:
  - ⇒ Providing an electronic download of the ICD-9-CM level data for current Medicare acute inpatient discharges.
- For all services:
- Allowing availability of key participants for all necessary meetings.
- Assisting with the scheduling of all necessary meetings, interviews, conference rooms and other facilities as mentioned above.
- Providing our consultants, while onsite, with access to a copier, a fax machine, analog phone lines and/or Internet connections. If the Hospital utilizes an electronic medical record, access to terminals will be provided to each of our consultants.

To the extent that 3M's deliverables include surveys, analyses, reports, evaluations, recommendations or other management consulting services, the Hospital will be responsible for any implementation decisions and for any future action with respect to the matters addressed in the deliverables.

Project Assumptions

The Services, professional fees and delivery schedule for this engagement are based upon the following assumptions, representations or information supplied by the Hospital ("Assumptions"):

- Discharge data will be provided in a timely manner and the parties involved will coordinate the scheduling of the Services.

- Patient records selected for review will contain the coding summary for each case and will be available to our consultants for the first day of the record review.

3M's delivery of the Services and the professional fees charged are dependent on: (i) the Hospital's timely and effective completion of the Hospital Responsibilities; (ii) the accuracy and completeness of the Assumptions; and, (iii) timely decisions and approvals by Hospital's management. The Hospital will be responsible for any delays, additional costs, or other liabilities caused by or associated with any deficiencies in the Hospital Responsibilities and Assumptions.

Engagement Team

Director of ICD-10 Consulting Services, will serve as the Operations Executive and will be responsible for the quality of work performed and the delivery of Services. Your team of consultants will include:

- *Medical record/coding specialists.* These credentialed consultants are highly skilled in areas of medical information systems and are coding experts. We rely on these specialists to advise the nursing consultants in the technical coding arena, as well as medical record department issues and concerns.
- All our consultants have been extensively trained in DRG assignment, physician communication, and adult teaching methodology, with direct emphasis in healthcare documentation and severity of illness criteria. Most have graduate degrees or extensive backgrounds as clinical managers in the hospital setting. Our goal is to "download" skills and learned information to you and your staff.

Staffing will be dependent upon availability at the time of your engagement acceptance. Resumes for engagement team members can be provided as requested once the engagement is scheduled. You will have the right of refusal for any member assigned to the engagement team.

Proprietary Information

As a condition of performing this work, you shall treat as proprietary and confidential all materials, forms, documents and information received in conjunction with the engagement (collectively referred to as "Confidential Information"). Without the express, prior written consent of 3M Consulting, Confidential Information: (i) may be distributed within your organization only to those individuals who have a need to know such information, and (ii) must not be distributed or made available, in whole or in part, to any third party.

In accordance with applicable state and federal confidentiality laws, we agree to maintain confidentiality of all information obtained in conjunction with this project and to follow appropriate procedures to determine that employee/patient confidentiality rights are not abridged.

Fees AND ARRANGEMENTS

The professional service fees (collectively, "3M Fees") contemplated under this arrangement letter are outlined in the Engagement Approval section, plus any out-of-pocket expenses incurred, including travel, meals and lodging. Out-of-pocket expenses will be invoiced at the actual amounts incurred. Please be assured that every reasonable effort will be made to minimize out-of-pocket expenses. All travel and expenses, for this engagement, will be paid per the Monterey County travel policy. Invoicing will occur as follows:

- At the completion of each selected ICD-10 Documentation Assessment.
- At the completion of the ICD-10 MS-DRG Financial Impact Analysis. The professional fees for the MS-DRG Financial Impact Analysis are based on our estimate of the time required to complete the analysis of your data and to provide the Executive Summary presentation.

The 3M Fees are based upon the assumption that there is no statutory-mandated assessment, deduction, fee, discount or other charge (collectively, "Assessment") that the Hospital is required, by state or local law, to withhold from its payment of the 3M Fees under this Agreement, and that in the event such an Assessment is made against the 3M Fees, the 3M Fees shall be increased by an equivalent amount, which 3M may invoice to Hospital. Additionally, the 3M Fees are based on the Hospital's fulfillment of the Hospital Responsibilities and Assumptions described in this arrangement letter.

The nature of this type of work is such that information may be developed and may require services that cannot be anticipated or budgeted. Should either of us identify appropriate changes in scope or should other matters arise that would affect our estimated total fee, we will discuss them with you before incurring additional fees and will amend this arrangement letter as necessary.

ATTACHMENT A

DATA SPECIFICATIONS

This document details the data file specifications, format and submission.
Protected Health Information (PHI)

It is 3M Consulting Services' policy to take appropriate safeguards to prevent unauthorized use or disclosure of Protected Health Information (PHI) as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). As a best practice, please ensure that PHI data is encrypted before it is emailed. 3M provides a free encryption tool which can be easily downloaded from our Internet website, http://performancemanagement.3mhis.com. If your facility has Secure Email, we will retrieve the data through your secure message center.

Submission Process of Your Secure/Encrypted Data to 3M

HIPAA requires that all protected health information be encrypted before being transmitted via the Internet. If you have a Secure Email System, we can retrieve the data from your system upon Secure Email Notification set to HI-3M-CS-Data@mmm.com. If you do not have Secure Email, *3M provides a free encryption tool which can be easily downloaded from our Internet website, http://performancemanagement.3mhis.com*
Complete instructions on how to install and use the tool is also available for download. The size of the encrypted file must be under 5MB to email. If it is over 5MB, please send an email to the 3M Consulting Services Data Team at HI-3M-CS-Data@mmm.com requesting a Web Drop Box be set up for transmitting the data.

If you have questions concerning file formats, encryption or delivery options please contact JoAnn Serlff (678-332-3726) or Kent Baker (678-332-3824). You may also email 3M's Consulting Services Data Team at HI-3M-CS-Data@mmm.com.

CONFIDENTIALITY -- Patient-Specific Protected Health Information
3M will retain the confidentiality of and appropriately safeguard any patient-specific information made available to, or generated by 3M. Without limitation to the obligations of 3M otherwise set forth by agreement or imposed by applicable law, 3M agrees to comply with the applicable requirements of law relating to protected health information and with respect to any task or other activity 3M performs, to the extent the Covered Entity, as defined in the final privacy regulations, would be required to comply with such requirements.

Professional
Claims Data – Encryption or Secure Email Required

Please submit a report of paid services for the primary payor for the prior one (1) or three (3) months as stated in the scope of work in your contract.

Please submit all data in a single file if possible. The data may be supplied in Microsoft Excel® or in a delimited text file as shown below.

Professional Services Data Specifications

Required	Field Description	Field Name	Data Type	Max Length	Format	Notes
No	Patient's Name	Patient_Name	Character	40		
No	Patient's Date of Birth	Patient_DOB	Date	10	mm/dd/yyyy	
No	Patient's Age	Patient_Age	Numeric	3		
No	Patient's Sex	Patient_Sex	Character	1		
Yes	Medical Record Number	Med_RecNo				Number assigned to the patient which typically remains the same regardless of the number of encounters
Yes	Patient's Account Number	Patient_Account_Number				Number assigned to the patient which must be unique for each encounter
Yes	Primary Payer's code or name	Primary_Payer	Character	20		Primary Payor (code or name)
Yes	ICD-9-CM Diagnosis code	Diagnosis1	Character	7		All diagnosis codes should contain both the leading and trailing zeros if the zero is normally part of that code. Therefore, in Excel the diagnosis columns must be formatted at Text.
Yes	ICD-9-CM Diagnosis code	Diagnosis2	Character	7		
Yes	ICD-9-CM Diagnosis code	Diagnosis3	Character	7		
Yes	ICD-9-CM Diagnosis code	Diagnosis4	Character	7		
Yes	Date of Service	Date_Of_Service	Date	10	mm/dd/yyyy	
Yes	Place of Service	Place_Of_Service	Character	2		
Yes	CPT or HCPCS	Procedure_code	Character	5		
No	Modifier 1	Mod1	Character	2		
No	Modifier 2	Mod2	Character	2		
No	Modifier 3	Mod3	Character	2		
No	Modifier 4	Mod4	Character	2		
No	Charge Amount	Charge_Amt	Numeric	10.2	0000000.00	
No	Paid Amount	Paid_Amt	Numeric	10.2	0000000.00	
Yes	Units of service	Days_or_Units	Numeric	3		
Yes	Provider ID code (NPI)	Provider_ID	Character	20		
No	Physician's Name	Physician_Name	Character	40		
No	Billing Provider Info	Billing_Provider_Info	Character	20		
Yes	Physician's Specialty (name or code)	Phys_Specialty	Character	40		

Outpatient
Claims Data – Encryption or Secure Email Required

Please submit claims data for one (1) or three (3) months as stated by the scope of work in your contract. Please use one of the following formats:

- ASC X12N 837: Health Care Claim Transaction Set (837). The data may be submitted in a single file or in multiple files. It may also contain both outpatient and inpatient claims and Medicare or all payers. We will filter the data to extract only the outpatient claims and specific payers according to your contract.
- UB-04 Print Images: This is defined as an ASCII text file that, if printed, would perfectly overlay the UB-04 form. The file can contain an unlimited number of claims; however, it should be free from other types of data, such as report headers or footers. The data may be submitted in a single file or in multiple files. It may also contain both outpatient and inpatient claims and Medicare or all payers. We will filter the data to extract only the outpatient claims and specific payers according to your contract.
- Minimum Data Set: If you are unable to supply the 837 or UB-04 print image format, you may supply a Microsoft Excel® or delimited text file as shown below. This file should only contain the Outpatient claims to be analyzed and should be in a single file.

Outpatient Minimum Data Set Specifications

Required	Field Description	Field Name	Data Type	Max Length	Occur.	Format	Notes
Yes	Unique Patient Identifier (account/visit/billing number)	PATID	Character	20	1		Number assigned to the patient which must be unique for each encounter
No	Patient Name	PATNAME	Character	30	1		Patient name
Yes	Medical Record Number	MEDRECNO	Character	15	1		Number assigned to the patient which typically remains the same regardless of the number of encounters
Yes	Admission date	ADMDATE	Character	10	1	mm/dd/yyyy	The beginning date of any outpatient encounter.
Yes	Discharge Date	DISDATE	Character	10	1	mm/dd/yyyy	The ending date fo any outpatient encounter.
No	Date of Birth	DOB	Character	10	1	mm/dd/yyyy	The date the patient was born
No	Sex	SEX	Character	1	1		Patient's sex
Yes	Principal Diagnosis	SecDXx x = 1-49	Character	7	1		ICD-9-CM diagnosis *See notes above.*
Yes	Secondary Diagnosis	SecPOAx x =1-49	Character	7	49		ICD-9-CM Secondary diagnosis *See notes above.*
Yes	CPT/HCPCS code	CPTx x=1-49	Character	5	49		CPT/HCPCS Codes *See notes above.*
Yes	Payor	PAYOR	Character	15	1		Primary Payor (code or name)
Yes	Campus/Facility Identifier	CAMPUS	Character	15	1		For Hospital Systems that report under one Medicare Provider Number but have contracted for separate reporting, please provide a facility/campus identifier to distinguish the different entities.

Contact for data specifications questions:

3M HIS Consulting Services

678-332-3742

gfchafin@mmm.com

Administrative Contact:

3M HIS Consulting Services

678-332-3722

kclardy@mmm.com

Data specifications may also be acquired at: *http://performancemanagement.3mhis.com*

Email Encrypted Data to the 3M Data Team at: HI-3M-CS-Data@mmm.com

Inpatient – Medicare or All Payor Data
Encryption or Secure Email Required

- PLEASE SUBMIT TWELVE (12) COMPLETE MONTHS OF INPATIENT DISCHARGE DATA

Please extract the data by discharge date, beginning with the first day of month one and ending with the last day of the month twelve.

If Medicare only, please submit PPS-paid Medicare inpatient discharges where Medicare is the primary payor. Include "Traditional Medicare" Acute Care discharges only (exclude Managed Medicare, SNF, Psych and Rehab Units).

Format of Data is Based on Your Medical Records System
3M Health Record Management **("HRM")**

- If you have 3M Health Records Management (HRM) software installed, please call 3M Customer Care at 1-800-435-7776 and request that the Consulting Services ICD-level Data Template be added to your HRM system. Once added, you will be able to run the data extract by discharge date in a similar manner to how you run reports.

3M ClinTrac™ Clinical Abstracting

- Please call 3M Customer Care at 1-800-435-7776 and request that the SDI package to create the ICD-Level extract be added to ClinTrac. Before calling 3M Customer Care, please have the following information available:
  - ⇒ Your SiteID
  - ⇒ The Medicare Provider Number and/or National Provider Identifier Number for your facility
  - ⇒ The Patient Type codes in ClinTrac for Inpatients
  - ⇒ The Financial Class Codes in ClinTrac for Medicare

If you are not a 3M HRM or 3M ClinTrac client, please visit our Internet website at *http://performancemanagement.3mhis.com* to access the ICD-9-CM Level Data Layout that your IT Department can use to create a data file from your Medical Records System.

- ➢ **On that page, under "DOWNLOADS" to go *3M CS Inpatient ICD-9 Data Layout* (do not select "Click here to enter the APC Oversight website").**

If you have questions concerning file formats, encryption or delivery options please contact JoAnn Seriff (678-332-3726) or Kent Baker (678-332-3824).

Contacts for data specifications file formats, encryption or delivery options:

3M HIS Consulting Services	3M HIS Consulting Services
678-332-3726	678-332-3824

You may also email 3M's Consulting Services Data Team at HI-3M-CS-Data@mmm.com.

Email Encrypted Data to the 3M Data Team at: HI-3M-CS-Data@mmm.com

This offer is valid for ninety (90) days from the date of this document.

A.	Please provide the REQUIRED INFORMATION in #1, #2, #3 and #4 below:		
	1.	Send Invoices to:	
		(a) Name:	
		(b) Title:	
		(c) Address (if different from page 1):	
		(d) Phone Number:	( )
	2.	Accounts Payable Contact:	
		(a) Name:	
		(b) Title:	
		(c) Phone Number:	( )
	3.	3M requires either (a) or (b):	
		(a) Purchase Order Number:	
		(b) Name of Authorizing Person:	
	4.	Contact for Engagement Scheduling:	
		(a) Name:	
		(b) Title:	
		(c) Phone Number:	( )
		(d) Email Address:	
B.	Is your organization tax exempt? _____Yes _____No If Yes, please ALSO SEND a copy of your current tax-exempt certificate, to avoid taxes being added to your invoices. A faxed copy is acceptable.		

EXHIBIT C

BUSINESS ASSOCIATE ADDENDUM

1. Parties:

Natividad Medical Center
Software License Agreement #o01553-10
1441 Constitution Boulevard
Salinas, CA 93906-3100
("Covered Entity")

3M Company, together with its subsidiaries and affiliates
575 West Murray Boulevard
Murray, UT 84123-4611
("Business Associate")

2. Purpose:

Business Associate may provide certain services as set forth in the Software License Agreement ("Agreement") to Covered Entity which may require the provision by Covered Entity of Protected Health Information ("PHI") and/or Electronic Protected Health Information ("EPHI") to Business Associate. As a result, Business Associate may be considered a Business Associate of Covered Entity as defined by the Health Information Insurance Portability and Accountability Act of 1996 ("HIPAA").

Business Associate and Covered Entity intend to comply with the applicable provisions of the HIPAA Privacy Rule and Security Regulations (45 CFR Parts 160, 162 and 164) ("Privacy Rule" and "Security Regulations", individually; or "Privacy and Security Regulations", collectively) and the applicable provisions of the Health Information Technology for Economic and Clinical Health Act, Title XIII of the American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5 (the "HITECH Act"). Therefore, to the extent required by HIPAA, and the HITECH Act and the regulations promulgated thereunder, Business Associate agrees to maintain the confidentiality of PHI and EPHI it receives from Covered Entity, if any.

3. Definitions.

Terms used in this Addendum shall have the same meaning as those terms in the Privacy and Security Regulations or the HITECH Act.

The terms Protected Health Information or PHI and Electronic Protected Health Information or EPHI when used in this Addendum shall have a meaning as defined by the Privacy and Security Regulations or the HITECH Act, but for the purposes of this Addendum shall be limited to PHI and/or EPHI received from, or created or received by Business Associate on behalf of, Covered Entity. Wherever the term PHI is used in a provision in this Addendum, it shall mean, include and be applicable to EPHI. Wherever the term EPHI is used, it shall mean and be applicable to EPHI only.

4. Obligations and Activities of Business Associate: Business Associate agrees, that with respect to PHI, it will:

a. not use or further disclose PHI other than as permitted or required by this Addendum or as Required By Law;

b. use appropriate safeguards to prevent use or disclosure of the PHI other than as provided for by this Addendum. Without limiting the generality of the foregoing, Business Associate will:

(i) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of EPHI that it creates, receives, maintains, or transmits on behalf of the Covered Entity;

(ii) Ensure that any agent, including a subcontractor, to whom it provides such EPHI agrees to implement reasonable and appropriate safeguards to protect it; and

(iii) Report to the Covered Entity any Security Incident related to an information system containing PHI of which it becomes aware;

c. report to Covered Entity, without unreasonable delay, any use or disclosure of the PHI not provided for in this Addendum of which it becomes aware;

d. to the extent Business Associate maintains or otherwise holds, uses or discloses Unsecured PHI, as defined under the HITECH Act, or guidance issued by the Secretary of the Department of Health and Human Services (the "Secretary"), without unreasonable delay, notify Covered Entity of any Breach (as defined under the HITECH Act) of Unsecured PHI of which Business Associate becomes aware Such report shall include at least, to the extent known, the identity of each individual whose information was, or is reasonably believed by Business Associate to have been, accessed, acquired or disclosed during the Breach,

d. ensure that any agent, including a subcontractor, to whom it provides PHI received from, or created or received by Business Associate on behalf of Covered Entity agrees to the same PHI restrictions and conditions that apply to Business Associate through this Addendum with respect to such PHI;

e. make available PHI maintained by Business Associate or its agents in accordance with this Addendum to Covered Entity upon reasonable notice and in accordance with applicable law in order to meet the requirements of 45 CFR §164.524;

f. to the extent Business Associate maintains PHI in a Designated Record Set, incorporate any amendments or corrections to such PHI in accordance with applicable law and to the extent applicable to this Addendum that Covered Entity directs or agrees to pursuant to 45 CFR §164.526 at the request of Covered Entity; Any such amendment or correction made to PHI in a Designated Record Set at the direction of the Covered Entity shall be the responsibility of the Covered Entity.

g. document disclosures of PHI made pursuant to applicable law and information related to such disclosures as would be required for Covered Entity to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR §164.528 or Section 13401(c)(3) of the HITECH Act;

h. make available to Covered Entity the information collected in accordance with Section 4(g) of this Addendum as is in the possession of Business Associate to satisfy the applicable requirements for an accounting of disclosures of PHI in accordance with 45 CFR §164.528 or Section 13401(c)(3) of the HITECH Act;

h. make internal practices, books, and records, relating to the use and disclosure of PHI received from Covered Entity, available to the Secretary of the United States Department of Health and Human Services, in a reasonable time and manner or as designated by the Secretary, for purposes of the Secretary determining Covered Entity's compliance with applicable law; and

i. mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Addendum.

5. Permitted Uses and Disclosures by Business Associate: Business Associate acknowledges that it may have statutory duties under the HITECH Act and Business Associate will comply with all applicable duties under the HITECH Act. Effective February 17, 2010, Business Associate will comply with all applicable provisions of 45 CFR §§164.308 ("Security Standards: General Rules"), 164.310 ("Administrative Safeguards"), 164.312 ("Technical Standards"), and 164.316 ("Policies and Procedures and Documentation Requirements"). In complying with 45 CFR §164.312 ("Technical Safeguards"), Business Associate shall consider applicable guidance issued by the Secretary pursuant to Section 13401(c) of the HITECH Act and, if a decision is made to not follow such guidance, document the rationale for that decision.

Except as otherwise limited in this Addendum, Business Associate may use or disclose PHI:

a. on behalf of, or to provide services to, Covered Entity, as provided for in the Agreement and in accordance with the Privacy Rule; Business Associate shall request, use and disclose only the minimum amount of PHI necessary to accomplish the intended purpose of such request, use or disclosure;

b. for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate, provided that, in the case of disclosure to third parties, Business Associate shall obtain reasonable assurances from the person or entity to whom the PHI is disclosed that it will remain confidential, be used or further disclosed only as required by law or for the purpose for which it was disclosed, and the person or entity will notify Business Associate of any instances of which it is aware in which the confidentiality of the PHI has been breached ;

c. to provide Data Aggregation services to Covered Entity as permitted by 45 CFR § 164.504(e)(2)(i)(B); and

d. to report violations of law to appropriate Federal and State authorities, consistent with § 164.502(j)(1).

e. as of the effective date of Section 13405(d) of the HITECH Act, Business Associate may not receive remuneration in exchange for PHI unless permitted by the HITECH Act or regulations issued by the Secretary, except that any remuneration received by Business Associate for activities involving the exchange of PHI that the Business Associate undertakes on behalf of Covered Entity under the Agreement shall not be a violation of this Section.

6. Obligations of Covered Entity: Covered Entity shall:

a. not provide Unsecured PHI to Business Associate. Any Secured PHI, as defined under the HITECH Act and guidance issued by the Secretary, disclosed by Covered Entity to Business Associate shall be secured by a technology standard that is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute and is consistent with guidance issued by the Secretary specifying the technologies and methodologies that render PHI unusable, unreadable, or indecipherable to unauthorized individuals.

b. notify Business Associate of any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 CFR § 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of PHI;

c. notify Business Associate of any changes in, or revocation of, permission by an individual to use or disclose PHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI;

d. notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI; and

e. provide only Secured PHI, as defined under the HITECH Act or guidance issued by the Secretary, to Business Associate. Any Secured PHI disclosed to Business Associate shall be secured by a technology standard that is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute and is consistent with guidance issued by the Secretary specifying the technologies and methodologies that render PHI "secured" as set forth in the HITECH Act.

7. Term and Termination

a. Term. The Term of this Addendum begins on the Effective Date (above), and ends when the Agreement between Covered Entity and Business Associate has terminated or all PHI provided by Covered Entity to Business Associate is destroyed or returned to Covered Entity, whichever is later.

b. Termination for Cause. If Business Associate breaches a material term of this Addendum, Covered Entity has the right, but not the obligation to either:

(1) Provide an opportunity for the Business Associate to cure the breach or end the violation;

(2) Immediately terminate the underlying Agreement(s) between Covered Entity and Business Associate; however, all rights and obligations arising prior to such termination shall remain in effect. All other Agreements between Covered Entity and 3M Company shall remain in effect in accordance with their terms; or

(3) report the violation to the Secretary in accordance with applicable law only in cases where neither termination nor cure are feasible.

c. Effect of Termination.

(1) Except as provided in paragraph (2) of this section, upon termination of this Addendum, for any reason, Business Associate shall return or destroy all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall also apply to PHI that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI except as provided for in this Addendum.

(2) In the event that Business Associate determines that returning or destroying the PHI is infeasible, Business Associate shall extend the security protections of this Addendum to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI.

8. Miscellaneous

a. Third Party Beneficiaries. Nothing expressed or implied in this Addendum is intended, nor shall be deemed, to confer any benefits on any third party.

b. Regulatory References. A reference in this Addendum to a section in the Privacy Rule or the Security Regulations means the section as in effect or as amended.

c. This Addendum supersedes and replaces any other agreement terms with 3M Health Information Systems with respect to the terms and obligations relating to HIPAA and PHI.

d. Amendment. The Parties agree to take such action as is necessary to amend this Addendum from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy and Security Regulations and the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191.

e. Survival. The respective rights and obligations of Business Associate under Section 7.c of this Addendum shall survive the termination of this Addendum.

f. Interpretation. Any ambiguity in this Addendum shall be resolved to permit Covered Entity to comply with the Privacy and Security Regulations.

FORM BAA 14JAN2010 PB

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EXHIBIT D

THIRD PARTY CONTENT TERMS AND CONDITIONS

PART I

AMA TERMS AND CONDITIONS

The following terms and conditions apply to Customer's use of 3M Software and Content containing *Current Procedural Terminology* and/or material published in *CPT® Assistant* (collectively referred to herein as "AMA Editorial Content") in addition to the terms and conditions set forth in the License Agreement ("Agreement"). In the event of a conflict between the terms and conditions in the Agreement and those set forth in this Exhibit D, with respect to Customer's use of the AMA Editorial Content, the terms and conditions of this Exhibit D shall control.

1. Grant of Rights Restrictions. Customer has a nontransferable, nonexclusive license to use the AMA Editorial Content contained within the 3M Software and Content solely for its internal purposes within the United States. Customer is prohibited from publishing, distributing via the Internet or other public computer based information system, creating derivative works (including translations), transferring, selling, leasing, licensing or otherwise making the AMA Editorial Content, or a copy or portion thereof, available to any unauthorized party. Customer's access to updated AMA Editorial Content depends upon a continuing contractual relationship between 3M and the AMA. Customer shall ensure that anyone with authorized access to the AMA Editorial Content will comply with the provisions of the Agreement, including this Exhibit D. Any printing or downloading of *CPT® Assistant* from the 3M Software and/or Content must be solely for Customer's internal use, without any modification to the content, and in such a way that all references to the AMA are included.

2. Notices. CPT and *CPT Assistant* are copyrighted works of the American Medical Association. CPT is a registered trademark of the American Medical Association. The following U.S. Government Rights notice shall apply: *U.S. Government Rights. This product includes CPT and/or CPT Assistant which is commercial technical data and/or computer data bases and/or commercial computer software and/or commercial computer software documentation, as applicable which were developed exclusively at private expense by the American Medical Association, 515 North State Street, Chicago, Illinois, 60610. U.S. Government rights to use, modify, reproduce, release, perform, display, or disclose these technical data and/or computer data bases and/or computer software and/or computer software documentation are subject to the limited rights restrictions of DFARS 252.227-7015(b)(2) (November 1995) and/or subject to the restrictions of DFARS 227.7202-1(a) (June 1995) and DFARS 227.7202-3(a) (June 1995), as applicable for U.S. Department of Defense procurements and the limited rights restrictions of FAR 52.227-14 (June 1987) and/or subject to the restricted rights provisions of FAR 52.227-14 (June 1987) and FAR 52.227-19 (June 1987), as applicable, and any applicable agency FAR Supplements, for non-Department of Defense Federal procurements.*

3. Backup Rights. Customer may make backup copies of the 3M Software and/or Content containing AMA Editorial Content for backup or archival purposes only provided that all notices of proprietary rights, including trademark and copyright notices, appear on all backup or archival copies made.

4. Warranty Disclaimer. TO THE FULLEST EXTENT POSSIBLE UNDER APPLICABLE LAW, ALL WARRANTIES (EXPRESS AND IMPLIED) INCLUDING WITHOUT LIMITATION ANY IMPLIED WARRANTIES OF MERCHANTABILITY, TITLE, NON-INFRINGEMENT OR FITNESS FOR A PARTICULAR PURPOSE AND THOSE ARISING FROM TRADE USAGE OR COURSE OF DEALING ARE DISCLAIMED WITH RESPECT TO THE AMA EDITORIAL CONTENT. CUSTOMER'S USE OF THE AMA EDITORIAL CONTENT AS CONTAINED IN THE 3M SOFTWARE AND/OR CONTENT IS "AS IS" WITHOUT ANY LIABILITY TO 3M OR THE AMA INCLUDING, WITHOUT LIMITATION, ANY LIABILITY FOR DIRECT, INDIRECT, INCIDENTAL, SPECIAL OR CONSEQUENTIAL DAMAGES, OR LOST PROFITS FOR SEQUENCE, ACCURACY, OR COMPLETENESS OF DATA, OR THAT THE AMA EDITORIAL CONTENT WILL MEET CUSTOMER'S REQUIREMENTS. THE SOLE RESPONSIBILITY OF THE AMA IS TO MAKE AVAILABLE TO 3M REPLACEMENT COPIES OF THE AMA EDITORIAL CONTENT IF THE DATA IS NOT INTACT. THE AMA DISCLAIMS ANY LIABILITY FOR ANY CONSEQUENCES DUE TO USE, MISUSE, OR INTERPRETATION OF INFORMATION CONTAINED OR NOT CONTAINED IN THE AMA EDITORIAL CONTENT.

EXHIBIT D

THIRD PARTY CONTENT TERMS AND CONDITIONS

PART II

HEALTH FORUM TERMS AND CONDITIONS

3M's Coding Reference Software contains AHA Coding Clinic™ for ICD-9-CM; and 3M's Coding Reference Plus Software contains ICD-9-CM Coding Handbook, Revised Edition, by Faye Brown, and AHA Coding Clinic™ for HCPCS. To the extent Customer has licensed the 3M Coding Reference Software or the 3M Coding Reference Plus Software, the following terms and conditions apply to Customer's use of such Software in addition to the terms and conditions set forth in the License Agreement ("Agreement"). In the event of a conflict between the terms and conditions in the Agreement and those set forth in this Exhibit D, with respect to Customer's use of such Software, the terms and conditions of this Exhibit D shall control.

ICD-9-CM Coding Handbook, Revised Edition, by Faye Brown, is copyrighted by Health Forum, LLC, Chicago, Illinois, which licenses its use. No portion of ICD-9-CM Coding Handbook may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, recording or otherwise, without the prior express, written consent of Health Forum, LLC.

It is understood that Health Forum, LLC did not enter the ICD-9-CM Coding Handbook information and data into the computer and therefore Health Forum, LLC is not responsible for the accuracy, completeness or appropriateness of the information. Health Forum, LLC, and 3M make no warranties of merchantability or fitness for a particular purpose. Health Forum, LLC, shall have no liability to anyone, including 3M and Customer, for lost profits or indirect or consequential damages. Health Forum, LLC, makes no warranties of any kind with respect to 3M, its products or services.

AHA Coding Clinic™ for ICD-9-CM is copyrighted by the American Hospital Association ("AHA"), Chicago, Illinois, which licenses its use. No portion of AHA Coding Clinic™ for ICD-9-CM may be copied without the express, written consent of Health Forum, LLC.

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AHA Coding Clinic™ for HCPCS is copyrighted by the American Hospital Association ("AHA"), Chicago, Illinois, which licenses its use. No portion of AHA Coding Clinic™ for HCPCS may be copied without the express, written consent of Health Forum, LLC.

It is understood that AHA did not enter the AHA Coding Clinic™ for HCPCS information and data into the computer and therefore AHA is not responsible for the accuracy, completeness or appropriateness of the information. AHA and 3M make no warranties of merchantability or fitness for a particular purpose. AHA shall have no liability to anyone, including 3M and the Customer, for lost profits or indirect or consequential damages. AHA makes no warranties of any kind with respect to 3M, its products or services.

The printing or downloading of ICD-9-CM Coding Handbook, AHA Coding Clinic™ for ICD-9-CM and AHA Coding Clinic™ for HCPCS (collectively, the "HF Documentation") or any portion thereof, is prohibited, other than the printing of an excerpt from HF Documentation on a specific topic without any modification to the excerpt for internal use only by the Authorized Site as long as the source of the excerpt(s) is printed on the printout(s).

The text of HF Documentation is and will remain inaccessible to other programs capable of generating paper printouts of HF Documentation (excluding the print screen functionality of Windows software) by encrypting all files containing source text of HF Documentation.

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CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 03/05/2012

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies)must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER Willis of Minnesota, Inc. c/o 26 Century Blvd. P. O. Box 305191 Nashville, TN 37230-5191	CONTACT NAME: PHONE (A/C, NO, EXT): 877-945-7378 FAX (A/C, NO): 888-467-2378 E-MAIL ADDRESS: certificates@willis.com
	INSURER(S)AFFORDING COVERAGE — NAIC #
	INSURER A: Old Republic Insurance Company — 24147-001
INSURED 3M Company 3M Insurance Department Bldg 224-58-29 St. Paul, MN 55144	INSURER B:
	INSURER C:
	INSURER D:
	INSURER E:
	INSURER F:

COVERAGES **CERTIFICATE NUMBER:** 17500298 **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN. THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADD'L INSRD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	GENERAL LIABILITY			MWZY 59131	3/1/2011	3/1/2014	EACH OCCURRENCE	$ 5,000,000
	[X] COMMERCIAL GENERAL LIABILITY						DAMAGE TO RENTED PREMISES (Ea occurence)	$ 1,000,000
	[ ] CLAIMS-MADE [X] OCCUR						MED EXP (Any one person)	$ 10,000
							PERSONAL & ADV INJURY	$ 5,000,000
							GENERAL AGGREGATE	$ 5,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						PRODUCTS - COMP/OP AGG	$ 5,000,000
	[ ] POLICY [ ] PRO-JECT [ ] LOC							$
A	AUTOMOBILE LIABILITY			MWTB 21146	3/1/2011	3/1/2014	COMBINED SINGLE LIMIT (Ea accident)	$ 3,000,000
	[X] ANY AUTO						BODILY INJURY(Per person)	$
	[ ] ALL OWNED AUTOS [ ] SCHEDULED AUTOS						BODILY INJURY(Per accident)	$
	[ ] HIRED AUTOS [ ] NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$
								$
	[ ] UMBRELLA LIAB [ ] OCCUR						EACH OCCURRENCE	$
	[ ] EXCESS LIAB [ ] CLAIMS-MADE						AGGREGATE	$
	[ ] DED [ ] RETENTION $							$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N			MWC116992 01	3/1/2012	3/1/2013	[X] WC STATU-TORY LIMITS [ ] OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? [N]	N/A					E.L. EACH ACCIDENT	$ 2,000,000
	(Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$ 2,000,000
							E.L. DISEASE - POLICY LIMIT	$ 2,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach Acord 101, Additional Remarks Schedule, If more space is required)

CERTIFICATE HOLDER

Evidence of Coverage

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

ACORD 25 (2010/05)

EXHIBIT B
INSURANCE JUSTIFICATION

Vendor/Contractor Name: 3M

General Liability Additional Insured Endorsement

Business Justification:
The vendor has provided proof of General Liability Insurance at the required amounts. Due to the type of service provided by the vendor NMC request the Agreement be approved and the requirement for General Liability Additional Insured Endorsement be waived.

Automobile Liability Additional Insured Endorsement

Business Justification:
The Vendor has supplied proof of Automobile Liability Insurance at the County required levels. NMC requests the Agreement be approved and the requirement for the Additional Insured Endorsement for Auto Insurance be waived.

Harry Weis
Chief Executive Officer

Date: 4/16/12